Friendly Foot Care, PA
Midwest Orthopedics Foot & Ankle, P.A.

Mark Landry, DPM, MS

11237 Nall Ave. Ste 130
Leawood, KS 66211
913-438-9898

Patient Information:

Last Name: _____ First Name: _____ MI: ____

Street Address: _____ Email address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Date of Birth(mm/dd/yyyy): _____ Social Security Number*: _____

Sex: ❑M ❑F Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

If patient is a minor, responsible party information:

Last Name: _____ First Name: _____ MI: ____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Date of Birth(mm/dd/yyyy): _____ Social Security Number*: _____

Sex: ❑M ❑F Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

Employment Information:

Status: ❑Employed ❑Unemployed ❑Disabled ❑Retired

Employer Name: _____

Occupation: _____

Physician Information:

Referring Physician Name: Landry? Phone: _____

Primary Physician Name: _____ Phone: _____

If no referring physician, how did you hear about Dr. Bonar? _____

_____

_____

*SSN is required for billing purposes

INSURANCE INFORMATION

PRIMARY INSURANCE:

Name of Insurance Company: _____

Policy Number: _____ Group Number: _____

****IF THE SUBSCRIBER IS NOT THE PATIENT:**

Subscriber Name: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Relationship to Patient: _____

SECONDARY INSURANCE:

Name of Insurance Company: _____

Policy Number: _____ Group Number: _____

****IF THE SUBSCRIBER IS NOT THE PATIENT:**

Subscriber Name: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Relationship to Patient: _____

MEDICARE PATIENTS ONLY:

I hereby authorize payment of my Medicare and benefits to Friendly Foot Care, PA for all claims filed on my behalf. This authorization applies to all services until it is revoked by myself or my representative.

Patient Signature: _____

Medicare Number: _____

PATIENT FINANCIAL POLICY

Friendly Foot Care, P.A. ("FFC") wants to thank you for choosing Dr. Landry for your podiatric needs. It is the patient's responsibility to provide their most current demographic and insurance information at each visit. If your insurance denies coverage, you will be personally responsible for payment of FFC's charges. If you are not covered under any insurance, you may be accepted as a "self-pay" and prepayment is required.

Co-Payments/Co-Insurance/Deductibles: Your insurance plan determines your co-pay/co-insurance/ deductible. Your co-pay/co-insurance/ deductible is due at each visit. If you do not know exactly what your insurance company will pay for the visit, we will estimate the co-pay/co-insurance/deductible due.

Referrals: If your insurance plan requires a referral from your Primary Care Physician, it is the patient's responsibility to call their insurance company and obtain any required referrals prior to the appointment.

Motor Vehicle Accident/Personal Injury Claims: Prior to your appointment, you must notify FFC if your injury is the result of a Motor Vehicle Accident or Personal Injury involving a potentially liable party. Prepayment is required unless you have arranged arrangements with FFC prior to your appointment. FFC will bill the liability insurance company if you provide all necessary billing information. You will be personally responsible for all charges in the event the liability insurance company does not pay.

Workers Comp Claims: Prior to your appointment, you must notify FFC if your injury is a result of a work place injury. Your employer, workers compensation insurance company, or attorney must authorize your treatment before your appointment.

Disability/FMLA/Insurance Forms: To cover the costs of our staff's labor, each form requires a prepayment of $40.00 for the first page and $7.00 for each additional page before the form(s) will be completed. Please allow 7-10 business days from receipt of the prepaid fee for them to be completed.

Medical Records: FFC charges $18.97 (base fee) plus $0.63 per page. X-rays cannot be copied; a digital copy must be accessed and printed or burned to a CD. Therefore, FFC charges $5.00 per x-ray to cover costs of supplies and labor. All charges must be prepaid. Please allow 7-10 business days from receipt of the prepaid charge for medical records to be available to pickup/fax/send. Copies of x-rays cannot be faxed.

Cam (Walker) Boots, Night Splints, Cast Covers: Cast covers and night splints are typically not covered by insurance. We charge $30 for cast covers and $60 for night splints due at check-out. Cam boots are covered by some insurance companies, but not all. For this reason, we charge $85 for cam boots – payment is due at check out. We then submit your claim to your insurance company. If your insurance company pays for the boot we will apply your $85 to any patient balances and send you a refund if there is any remainder.

Returned Check Fee: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being charged a $25.00 fee per check returned.

By signing below you attest that you have read and fully understand FFC's Patient Financial Policy. If you do not make payment for services owed, FFC will take all necessary and appropriate action to collect any money due on your account, but not limited to the use of collection agencies or attorneys. You will be responsible for any and all fees associated with these collection efforts.

Signature of Patient/Guardian: _____ Date: _____

Printed Name of Patient/Guardian: _____

Consent to Use and Disclosure of Protected Health Information for Purposes of Treatment, Payment, and Health Care Operations

As a condition of providing treatment to you, Friendly Foot Care, PA, obtains your consent to use and disclose protected health information about you to carry out treatment, payment, and the health care operations of Friendly Foot Care, PA.

You may revoke this at any time by notifying Friendly Foot Care, PA, in writing, except to the extent Friendly Foot Care, PA, has taken action and reliance on your consent.

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that Friendly Foot Care, PA, may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

Friendly Foot Care, PA has reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request Friendly Foot Care, PA to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. Friendly Foot Care, PA is not required, however, to agree to such requested restrictions. If, however, Friendly Foot Care, PA agrees to the requested restriction, Friendly Foot Care, PA will honor the request and it will be binding on Friendly Foot Care, PA.

I hereby consent to the use and disclosure by Friendly Foot Care, PA, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

__**Yes** __**No** Employees of Friendly Foot Care, PA may leave confidential information regarding scheduling, test results, or other information requested by me on my answering machine or voice mail.

__**Yes** I have received a copy of the Notice of Privacy Practices for Protected Health Information from Friendly Foot Care, PA.

_____
Signature

_____
Signature of Personal Representative of Patient

_____
Description of Representative's Authority to Act for Patient

_____
Date

Friendly Foot Care, PA

Date: _____

Name: _____ Age: _____
Name of Doctor or Person who referred you? _____

CHIEF COMPLAINT:
What are we seeing you for today (i.e. right heel pain, left foot pain, ankle pain)? _____

HISTORY OF PRESENT ILLNESS:
Was this an injury or accident or did it start gradually? _____

If this is an *injury* or *accident*:
In what state did the injury or accident occur? _____
Where did the injury occur (i.e. work, home, church)? _____
How did it happen? _____
When did it occur? _____
Where were you initially (i.e. St Joseph's Emergency Room)? _____
How were you treated (i.e. x-rays, splint, pain meds, crutches, ice elevation, other)? _____
_____

If this came on *gradually*, or since the injury, how have you been treated? _____
(i.e. x-rays, inserts, shots, physical therapy, non-steroidal medication)

Have any special test been done?
- ❒ Bone scan, results: _____
- ❒ MRI, results: _____
- ❒ CT scan, results: _____

How long has this been going on (i.e. 1 week, 3 months, 4 years)? _____

Do you have pain daily? ❒ Yes ❒ No
Does it cause you to limp? ❒ Yes ❒ No
Does it keep you from doing things you enjoy? ❒ Yes ❒ No
Such as (i.e. golfing, walking)? _____
When does it hurt the most (i.e. first thing in the morning, throughout the day, at night? _____

Do you have: ❒ Swelling ❒ Locking or Catching ❒ Giving way? (Check all that apply)
Does it wake you up at night or keep you awake? ❒ Yes ❒ No
What aggravates it? ❒ Standing ❒ Walking ❒ Sitting ❒ Other _____
What makes it feel better? ❒ Elevation ❒ Ice ❒ Wraps ❒ Staying off it ❒ Other _____

Have you had any previous surgeries or injuries of this body part? ❒ Yes ❒ No
If yes, please explain: _____
_____

Do you do any regular exercise? Yes/No, If you please explain:
- ❒ Stair stepper/ stair master
- ❒ Walking: How often? _____ How far? _____
- ❒ Running: How often? _____ How far? _____

Physician Signature: _____

Friendly Foot Care, PA

PAST MEDICAL HISTORY

Name: _____ Age: _____ Date: _____

List all past operations *Year* *Outcome*

_____

_____

_____

_____

Do you have a history of:

Heart Disease	YES ❑ NO ❑
Cancer	YES ❑ NO ❑
Diabetes	YES ❑ NO ❑
Bleeding Ulcer	YES ❑ NO ❑
Blackout/Fainting	YES ❑ NO ❑
Epilepsy	YES ❑ NO ❑
Digestion/Stomach	YES ❑ NO ❑
Rheumatoid Arthritis	YES ❑ NO ❑
Polio	YES ❑ NO ❑
TB	YES ❑ NO ❑
AIDS	YES ❑ NO ❑
Hepatitis	YES ❑ NO ❑

Do you have problems with:

Lungs/Breathing	YES ❑ NO ❑
Stomach Problems	YES ❑ NO ❑
High Blood Pressure	YES ❑ NO ❑
Bleeding/ Blood clots	YES ❑ NO ❑
Eyes	YES ❑ NO ❑
Ears/Nose/Throat	YES ❑ NO ❑
Bowel movement	YES ❑ NO ❑
Bladder	YES ❑ NO ❑
Numbness/Tingling	YES ❑ NO ❑
Balance	YES ❑ NO ❑
Psychological	YES ❑ NO ❑
Other _____	

Please explain if you checked yes to anything above: _____

_____

_____

Please list all medications you are currently taking:

Medicine **Dose** **Frequency** **For what illness**

_____

_____

_____

Do you have a latex allergy? YES ❑ NO ❑

List any allergies to medications or food and adverse reactions:

_____

_____

Do you smoke? YES ❑ NO ❑ How many cigarettes per day? _____

Do you drink alcohol? YES ❑ NO ❑ How many drinks per week? _____

Has any family member had a history of serious illness? YES ❑ NO ❑

If yes, please describe: _____

Has any member of your family been seen in our office before? YES ❑ NO ❑

If so, who? _____

Occupation: _____

How long have you worked there? _____

Physician's Signature: _____